Individual Written Rehabilitation Plan (IWRP)

State File #: _____
Soc. Sec. No: _____

Claimant Name: _____

PART I

VR Goal (This must be a specific job or job category):
Physical capabilities for the proposed vocational goal have been reviewed with physician? ☐ **YES** ☐ **NO**

PART II

Return To Work Priority (How will the goal be achieved):

Estimated Plan Completion Date:

PART III

Rationale For The Selection Of The Vocational Goal:

PART IV

OBJECTIVE 1:

Services:

Evaluation Method / Criteria:

OBJECTIVE 2:

Services:

Evaluation Method / Criteria:

PART V

Costs:

PART VI

RESPONSIBILITIES WITH SIGNATURES:

Counselor:

Claimant:

Carrier:

CLAIMANT'S UNDERSTANDING:

This plan **may** be interrupted or terminated if you fail to fulfill your responsibilities to:

- Meet your responsibilities in carrying out this plan
- Perform job search activities identified in this plan
- Attend all appointments and scheduled activities
- Notify your counselor of any change which will impact on your ability to complete or participate in this plan
- Attain passing grades in any and all training
- Follow medical or other professional's instructions

FAILURE TO COOPERATE IN YOUR PLAN OR MAKING REASONABLE PROGRESS TOWARDS EMPLOYMENT **MAY** RESULT IN SERVICES BEING DISCONTINUED.

I have read and understand the contents of the vocational rehabilitation plan as described in this document and my signature represents that I agree to faithfully execute my responsibilities described in it.

SIGNATURES:

_____ _____

Employee Signature Date

_____ _____

V R Counselor / Intern Signature Date

_____ _____

V R Supervisor (If Applicable) Date

_____ _____

Claim Representative Signature Date

_____ _____

Commissioner of Labor/Designee Date

Grounds for refusal to sign: